Child Health Services Summary

The following summary applies to child health services provided for both Medicaid and non-Medicaid children. For complete guidelines for services, refer to the EPSDT *Care for Kids* Information and Care Coordination Handbook, the I-Smile Oral Health Coordinator Handbook, and the Medicaid Screening Center Manual. The following information is based upon Medicaid and Child Health program guidelines as known to date. Information is presented in three categories: Presumptive Eligibility, Informing & Care Coordination, and Direct Care Services.

Presumptive Eligibility

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Presumptive Eligibility *Note: To provide PE services, all agency **hawk-i** outreach coordinators and other MCH staff must be certified as Qualified Entities (QE) under the supervision and authority of a Presumptive Provider Organization (agency). To become a QE, staff must complete web-based training provided by DHS.*	Presumptive Eligibility (PE) for children allows children to obtain Medicaid covered services while a formal Medicaid eligibility is being determined by the Iowa Department of Human Services. Duties of a Qualified Entity (QE) include: • Date stamp the application for PE for children when received by the QE • Clarify information on the application, if necessary • Inform the family that all applications are referred to DHS for ongoing Medicaid eligibility determination • Enter information from the application into the PE system (MPEP –Medicaid Presumptive Eligibility Portal) • Provide a Notice of Action (NOA) to the family that reflects the information entered from the application within 2 business days of the date stamped on the application • Maintain documentation to support the PE decision for the child(ren). This may include but is not limited to the application, clarification of any information provided by the family, and copy of the NOA.	In CAReS: Document the presumptive eligibility determination for each child in the family under the Informing and Care Coordination Services category. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Issues addressed, information from family, result of NOA, documents kept on file, documents given to family, informed of PE coverage of Medicaid covered services 5. First and last name of QE & credentials if not entering own data. Keep tracking log of this information and also full signatures, initials, and CAReS user names.	1. A family requesting presumptive eligibility for a child must complete the Application for Health Coverage and Help Paying Costs (Form 470-5170) ***AND*** the Addendum to the Application for Presumptive Eligibility. 2. The PE system will electronically transmit the PE application to DHS for review of ongoing Medicaid Eligibility. DO NOT send the application or NOA to DHS or IDPH. 3. The QE must keep records of the PE determinations (application, clarifications of info on the application, and a copy of the NOA).	Bill cost of presumptive eligibility determination to IDPH ***hawk-i*** outreach funds per family (not per child). Include supporting documentation.
For more information on Presumptive Eligibility or becoming a Qualified Entity, call 855-889-7985 or email IMEMPEPSupport@dhs.state.ia.us.				

Informing & Care Coordination

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Informing	Explaining the services available under Medicaid's EPSDT program to families of newly Medicaid enrolled children. This service applies to children on the CAReS Informing List. Informing consists of: ♦ initial inform: first contact made on behalf of a newly eligible child – typically written communication ♦ inform follow-ups: attempts to make personal contact with the family (phone, face-to-face, written) ♦ inform completion: personal contact made with the family via phone or face-to-face to dialogue about the services available under EPSDT and needs of the family. This is the purpose of informing. Inform newly eligible clients within 30 days of the beginning of each month.	In CAReS: Document the initial inform, inform follow-ups, and inform completion for each newly Medicaid eligible child in the family. *Initial Inform* 1. Date of service 2. Place of service (if not agency main address) 3. Month and year client is on Informing List 4. Informing letter or packet was sent 5. First and last name of service provider & credentials if not entering own data. *Inform Follow-up* 1. Date of service 2. Place of service (if not agency main address) 3. The actual (specific) time of day the attempt was made. 4. Description of the attempt to reach the family and the result of this attempt. Report a summary of phone messages left. 5. First and last name of service provider & credentials if not entering own data.	1. The informing service does not end with the mailing of an initial inform letter/packet. Inform follow-ups and/or completion is required. Inform completion is the ultimate goal of the service. 2. Either follow-ups or completions are to be accomplished in the month of the initial informing service. 3. For families with a phone number, any informing follow-up letter is sent only following failed phone attempt(s). 4. Inform completion consists of direct dialogue with the family and cannot be accomplished through written methods or by leaving phone messages. 5. If a family hangs up prior to explaining EPSDT services, the informing service would not be considered complete. This would be considered an inform follow-up. 6. The entirety of the inform completion contact is part of informing. Do not bill care coordination for any portion of this contact. 7. Informing is not a service repeated month after month for a family. Documentation for initial informs must be completed by the end of the month to assure that families will not appear on Informing Lists in subsequent months. 8. Verbal contact with the family within 12 months of the initial inform provides the opportunity for completing the informing service. If 1st verbal contact is beyond 12 months of the initial inform, provide care coordination.	Bill cost of informing to IDPH for the family (not per child). Include supporting documentation. The billing for informing includes the initial inform, inform follow-ups, and inform completion activities. Billing for the entirety of the informing process may occur following the provision of the initial inform. If there is more than one child in the family, submit the claim under the name of the youngest child on the Informing List.

		Inform Completion 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Explanation of full benefits and services within EPSDT 5. Immunization status 6. Timeframe of past or upcoming medical and dental appointments 7. Names of medical and dental providers 8. Information on other community resources to meet client needs 9. Other issues addressed 10. Feedback and information from the family (understanding) 11. Outcomes including referrals made and plans for follow-up 12. First and last name of service provider & credentials if not entering own data. Maintain a signature log of first and last name of provider, credentials, full signature, initials, and CAReS user names.		
For more information on informing services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Care coordination	Helping a client to access the health care system (medical, dental, mental health or other Medicaid programs/services). It includes: ♦ Providing information about available medical, dental, mental health and support services based on family need ♦ Answering questions about health care coverage ♦ Assisting with establishing medical and dental homes ♦ Advocating for the child ♦ Working with private providers on behalf of the child ♦ Reminding families that well child screenings are due. This involves two CAReS Reports: 1. Care Coordination List – In Agency (Due for a well child screen in agency home.) 2. Care Coordination List – No Agency (Due for a well child screen & never in an agency home) ♦ Assisting with scheduling appointments (outside agency) ♦ Follow-up to assure that clients received services ♦ Assisting with missed appointments ♦ Arranging for medical transportation or interpreter ♦ Completing components of the CHDR – Development; Family History; Social History; Family Risk Factors; Anticipatory Guidance	In CAReS: 1. Document care coordination under the Informing and Care Coordination Services category. 2. Mark "Physical Exam Referral" if the care coordination includes a referral for a medical exam or medical treatment. 3. Document dental care coordination under the Dental Services category. Time in and time out including a.m. and p.m. is required. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Issues addressed and Medicaid related concerns that the client /family shared 5. Staff responses to client/family concerns and issues 6. ***If*** coordinating periodic medical or dental check-ups: • Status of immunizations • Timeframe of past or upcoming medical and dental appointment • Names of medical and dental providers 7. Specific information on referrals 8. Details on outcomes and plan for follow-up as needed	1. Must involve phone or face-to-face contacts with the family or provider(s) on behalf of child. 2. Must involve helping to access medical, dental, mental health or other Medicaid related programs/services. 3. May not bill care coordination for ▪ written reminders for check-ups ▪ activities in an inform completion ▪ unsuccessful attempts to reach families ▪ activities that are part of the postpartum home visit ▪ activities that are part of direct care e.g., Do not bill cc for ○ Making CH agency appointments ○ Reporting lab results to the family/medical home for tests conducted by the CH agency ○ Referral for treatment resulting from direct care provided by the CH agency 4. Care coordination to arrange transportation may occur on the same day as a direct care service. 5. Interpretation for care coordination may be billed on the same day as the care coordination service.	Bill cost of Title XIX care coordination services (medical and dental) to IDPH per client as fee-for-service. Include supporting documentation that identifies payer source and contains the number of minutes spent on each Title XIX care coordination service. Payment for care coordination for Title V clients is through grant funds.

		9. Feedback and information from the family (e.g. understanding) 10. First and last name of service provider & credentials if not entering own data. If using the CHDR: Identify completion of specific CHDR components, summarize topics discussed, and report outcomes including referrals made and plans for follow-up. If providing care coordination for transportation: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Type of Medicaid service the client is receiving from the trip (e.g. medical, pharmacy, dental, mental health) 5. Date of planned trip 6. Type of ride to be provided (cab, bus, volunteer, TMS) 7. First and last name of service provider & credentials if not entering own data. Maintain a signature log of first and last name of provider, credentials, full signature, initials, and CAReS user names.	6. Medical care coordination may be billed if a dental direct service is provided by other staff (RDH) on the same day (only if no medical direct care was provided). 7. Dental care coordination by RDH may be billed if a medical direct service is provided by other staff on the same day (only if no dental direct care was provided). 8. Do not mark "Dental Referral" in CAReS when it is a part of dental care coordination. 9. Care coordination may be provided to meet a variety of needs for a client. Staff may care coordinate periodic well child check-ups. They may also provide care coordination that is targeted to other specific client needs.	
For more information on care coordination services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Texting for care coordination	Helping a client to access the health care system (medical, dental, mental health or other Medicaid programs/services) through the use of text messaging. A two-way text exchange is required.	In CAReS: ♦ Document care coordination under the Informing and Care Coordination Services category. ♦ Document dental care coordination under the Dental Services category. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Use "other" as the interaction type 4. Who texted with 5. Issues addressed in the text exchange, information from family, services declined, outcomes, referrals 6. Time in and time out including a.m. and p.m. (estimated time texting, reading, and responding) 7. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information and also full signatures, initials, and CAReS user names.	• Texts with no response are not billable. • Medicaid related services must be the central topic of the care coordination exchange. • Texts may not include protected health information (such as social security number, Medicaid ID# or NOD#).	Bill cost of Title XIX care coordination services (medical and dental) to IDPH per client as fee-for-service. Include supporting documentation that identifies payer source and contains the number of minutes spent on each Title XIX care coordination service. Payment for care coordination for Title V clients is through grant funds. Do not exceed one 15-minute unit when billing texting for care coordination.
For more information on care coordination services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
E-mailing for care coordination	Helping a client to access the health care system (medical, dental, mental health or other Medicaid programs/services) through the use of e-mail. This is typically used only when phone or face-to-face care coordination is not possible. A two-way e-mail exchange is required. A protocol for saving the e-mail communications must be developed by the agency (e.g. client chart, paper file, or electronic file).	In CAReS: ♦ Document care coordination under the Informing and Care Coordination Services category. ♦ Document dental care coordination under the Dental Services category. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Use "other" as the interaction type 4. Who e-mailed with 5. Issues addressed in the e-mail exchange, information from family, services declined, outcomes, referrals 6. Maintain e-mail communications per protocol. 7. Time in and time out including a.m. and p.m. (estimated time e-mailing, reading, and responding) 8. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information and also full signatures, initials, and CAReS user names.	• E-mails with no response are not billable. • Medicaid related services must be the central topic of the care coordination e-mail exchange. • Use of personal e-mail accounts is NOT allowed. E-mails sent must be from the employee's agency e-mail address. All responses from the client or provider must be sent to the employee's agency e-mail address. • Assure that any e-mails containing protected health information are sent via a Secure Mail system. • Unsecured email may NOT include protected health information such as social security number, Medicaid ID#, or NOA#. • Full disk encryption is especially important and required on computers used. • Agencies must assure that electronic information is protected through regular system back-ups. (See MCH Administrative Manual Policy 309.)	Bill cost of Title XIX care coordination services (medical and dental) to IDPH per client as fee-for-service. Include supporting documentation that identifies payer source and contains the number of minutes spent on each Title XIX care coordination service. Payment for care coordination for Title V clients is through grant funds.
For more information on care coordination services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Home visit for care coordination	When a home visit is made for the purpose of providing care coordination services. This includes care coordination for a medical/dental/mental health condition to: ♦ Provide information about health care services. ♦ Coordinate access to care and/or care with provider ♦ Assist in making health care appointments ♦ Make referral appointments ♦ Coordinate access to needed medical support services (transportation or interpreter services) ♦ Follow-up to assure services were received. A home visit may also be made by an RN to follow-up on a blood lead level equal to or greater than 15 µg/dL. This includes: ♦ A skilled assessment and instructions to the family ♦ Assistance with making and keeping follow-up appointments ♦ Reminding caregiver to notify child's lead case manager if the family moves ♦ Reminding caregiver to inform the child's current and future health care providers of elevated blood lead level	In CAReS: Document the care coordination service. Select "home visit" as the interaction type. Mark "Physical Exam Referral" if the care coordination results in a referral for a well-child exam in the medical home. Include in CAReS: 1. Date of service 2. Place of service 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. Time in and time out including a.m. and p.m. 6. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information and also full signatures, initials, and CAReS user names.	1. Use only face-to-face time to determine minutes of service. Do not include travel time when determining minutes of service. 2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill child health care coordination for any part of this maternal health visit. 3. If the purpose of the home visit is to provide direct care services, home visit for care coordination cannot be billed. If the purpose of the home visit is for nursing or social work services, use codes S9123 for the home visit for nursing services or S9127 for the social work home visit. (See guidelines below.)	Bill cost of Title XIX home visit for care coordination to IDPH per client as fee-for-service. Include supporting documentation that identifies payer source and contains the number of minutes spent on each Title XIX care coordination service (face-to-face time only). Payment for care coordination for Title V clients is through grant funds.
For more information on the home visit for care coordination, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.				

Direct Care Services

Specific direct care services provided by a Title V Child Health agency are identified in the approved application submitted to IDPH for the Child Health program.

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Medical transportation (local)	Transportation to *local (in-town)* medical, dental, mental health services. Includes transportation parking fees and tolls.	In CAReS: Document under Health Screening Services category. Mark "Transportation to Health Provider" for in-town transportation services. Include in CAReS: 1. Date of service 2. Who provided the service (e.g. name of cab company or volunteer driver) 3. Address of where recipient was picked up 4. Destination (medical provider's name and address) 5. Invoice of cost 6. Mileage if transportation is paid per mile If the Title V agency keeps a service log containing the above information, the service note in CAReS must include a reference to this record.	1. Transportation must be to a Medicaid covered service. The transportation service must be on the date the Medicaid service was received. 2. Local transportation billed should align with the agency's Transportation Plan. 3. There is no payment for the transportation service if the client does not show up for the ride. 4. This does not include out-of-town transportation services. 5. Transportation Management Systems (TMS) is the Medicaid broker for transportation services. TMS arranges and pays for transportation (both in-town and out-of-town) to Medicaid covered medical, dental, and/or mental health appointments for Medicaid enrolled children. Contact TMS at 1-866-572-7662.	Code A0110: Non-emergency bus (per round trip) Code A0100: Non-emergency taxi (per round trip) Code A0130: Non-emergency wheel chair van (per round trip) Code A0090: Non-emergency by volunteer (per mile) Code A0120: Non-emergency mini-bus or non-profit transportation system (per round trip) Code A0170: Parking fees, tolls Bill actual cost of transportation for the date the transportation was provided to the health related appointment.
For more information on transportation services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook and Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Interpretation services	Services that include: • Sign language or oral interpretive services • Telephonic oral interpretive services	In CAReS: Document under Health Screening Services category. Mark "Interpretation". For telephonic oral interpretive services, mark 'phone' as the Interaction Type. Include in CAReS or client's chart: 1. Date of service 2. Time in and time out 3. The service for which the interpretation was provided 4. Name of interpreter or company 5. Cost of service If the Title V agency keeps a service log containing the above information, the service note in CAReS must include a reference to this record.	1. Billable interpretation services are provided by interpreters who provide **only** interpretation services. Agency staff with other roles cannot have split FTEs that include billable interpretation. 2. Interpreters are either employed or contracted by the Medicaid provider agency billing the services. 3. Service providers who are also bilingual are not reimbursed for interpretation, only for their medical/dental services. 4. Interpretation services must facilitate access to Medicaid covered services. Providers may bill Medicaid only if the services are offered in conjunction with another Medicaid covered service. 5. There is no payment for written translation of printed documents. 6. It is the responsibility of the provider to determine the interpreter's competency. • Sign language interpreters should be licensed pursuant to IAC 645 Chapter 361. • Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org).	Code T1013 for sign language or oral interpretive services (15 minute unit) For determining 15 minute units: • 8-22 minutes = 1 unit • 23-37 minutes = 2 units • 38-52 minutes = 3 units • 53-67 minutes = 4 units Reimbursable time may include the interpreter's travel and wait time. Code T1013 with UC modifier for telephonic oral interpretive services (per minute unit) Use the diagnosis code that pertains to the service being interpreted. If the interpretation is for informing or care coordination, use Z76.89 for the ICD10 diagnosis code.
For more information on transportation services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook and Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Health screening (well child exam)	The initial or periodic well child screen per the Iowa Recommendations for Scheduling *Care for Kids* Screenings (Periodicity Schedule) and as described in the Medicaid Screening Center Manual.	In CAReS: Under Health Screening Services category, mark "Physical exam – Direct" for well child screens provided by the child health agency. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2).	When providing direct care services, any care coordination provided on the same date of service is considered part of the direct care service. Do not bill this activity separately as care coordination. Examples include: ▪ Reporting lab results to the family or medical home from tests conducted at the Title V agency cannot be billed as care coordination. It is considered part of the direct care. ▪ Arranging an appointment for treatment services resulting from a well-child screen provided by the Title V agency cannot be billed as care coordination. It is considered part of the direct care. Document any care coordination activity in conjunction direct care as part of the documentation for the direct care service. *Objective* visual acuity screens (99173) and *objective* speech audiomentry (92555) are billed separate from the well child exam code if provided on the same day. See guidelines below.	Initial screen: Code 99381: 0-12 mo. Code 99382: 1-4 yr. Code 99383: 5-11 yr. Code 99384: 12-17 yr. Code 99385: 18-21 yr. Periodic screen: Code 99391: 0-12 mo. Code 99392: 1-4 yr. Code 99393: 5-11 yr. Code 99394: 12-17 yr. Code 99395: 18-21 yr. Use modifier U1 for a screen that results in a referral for treatment.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Oral Health Services	Services: ♦ Initial oral screen by a non-dentist, once or again if not seen in 3 years ♦ Periodic oral screen by a non-dentist, every 6 mo. ♦ Initial oral exam by a dentist, once or again if not seen in 3 years ♦ Periodic oral exam by a dentist, every 6 mo. ♦ Oral evaluation and counseling with primary caregiver for patient under 3 yr of age, every 6 mo. ♦ Caries risk assessment and documentation, with a finding of low, moderate or high risk (provided with every screen) ♦ Child prophylaxis, every 6 mo. ♦ Adult prophylaxis, every 6 mo. ♦ Sealant, once per tooth ♦ Bitewing x-ray, single film, once over 12 mo. ♦ Bitewing x-ray, two films, once over 12 mo. ♦ Bitewing x-ray, four films, once over 12 mo. ♦ Topical application of fluoride varnish, 4 times a year at least 90 days apart ♦ Nutritional counseling for the control and prevention of oral disease, every 6 mo. ♦ Oral hygiene instruction ♦ Dental care coordination	In CAReS: • Mark appropriate service under the "Dental Services" category. • Enter all services (whether billable or not). ♦ Document dental care coordination under the Dental Services category. Include in CAReS: 1. Time in and time out including a.m. and p.m. for timed based services (Codes D1310 and D1330.) 2. First and last name of service provider & credentials if not entering own data. 3. Reference client's chart for full description of services provided. 4. Note the client's risk assessment level each time a screening is provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. A dental referral must be provided at the time of each oral screen/exam. 2. When providing direct oral health services, care coordination activity provided on the same date of service is considered part of the direct care service. Do not bill this separately as care coordination. Example: • Assistance provided on the same day as a direct dental service (e.g. oral screen) is considered part of the direct care and is not billable care coordination. • Follow-up to the referral that is done on subsequent days (from the direct service) can be billed as care coordination. 3. If an initial screen is provided by a non-dentist, use only Code D0190 with a CC modifier. When providing subsequent screens, use either D0190 (no modifier) or D0145 as appropriate. 4. If an initial exam is provided by a dentist, use only Code D0150. When providing subsequent exams, use either D0120 or D0145 as appropriate. 5. The client's risk level must be assessed and recorded each time an oral screening is provided. 6. Code D0145 is billable only for children under three years of age if counseling with the primary caregiver is provided during a screen. 7. Codes D0145 and D1330 cannot be billed on the same date. 8. For Codes D1310 and D1330, a minimum of 8 minutes must be provided to bill the service.	♦ D0190 w/CC modifier: Initial oral screen by non-dentist (Add TD modifier when provided by RN) ♦ D0190: Periodic oral screen by non-dentist (Add TD modifier when provided by RN) ♦ D0150: Initial oral exam by dentist ♦ D0120: Periodic oral exam by dentist ♦ D0145 DA: Oral evaluation and counseling with caregiver (child under age 3) (Add TD modifier when provided by RN) ♦ Risk Assessment (One per screen, add TD modifier when provided by RN) ○ D0601 Low risk ○ D0602 Moderate risk ○ D0603 High risk ♦ D1120: Prophy (age 12 yr. and younger) ♦ D1110: Prophy (age 13 yr. and older) ♦ D1351: Sealant per tooth (posterior teeth up to age 18) ♦ D0270: Single bitewing film ♦ D0272: Two bitewing films ♦ D0274: Four bitewings films

	(Refer to Care Coordination on pages 4-7.)		9. For both sealant applications and bitewing films, report the number of teeth sealed or the number of bitewing films taken, not the number of clients that will receive the service. 10. Prophylaxis, sealants, and bitewings must be provided by an RDH only. 11. For services provided by a RN, the TD modifier must be included with the procedure code for dental screening, fluoride varnish, and counseling codes. 12. Assure that one of the diagnosis "Z" codes is provided for each procedure code. 13. If diagnosis codes Z01.21 is used, dental screen with abnormal findings, at least one of the K diagnosis codes must be included. Use as many K codes as needed.	♦ D1206: Topical fluoride varnish (Add TD modifier when provided by RN) ♦ D1310: Nutritional counseling for control & prevention of oral disease (15 minute unit) (Add TD modifier when provided by RN) ♦ D1330: Oral hygiene instruction (15 minute unit) (Add TD modifier when provided by RN)
For more information on oral health direct care services, refer to the I-Smile Handbook and Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Immunization administration with counseling	Administration of immunizations and counseling for children through 18 years of age. It includes • Immunization administration through any route. • Counseling by a qualified health professional. Counseling for each component of the vaccine is required. It shall include reviewing immunization records, explaining the need for the immunizations, and providing anticipatory guidance (education) & follow-up instructions when administering vaccine. It includes provision of the most current VIS.	In CAReS: Under Health Screening Services category, mark "Immunization". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client's chart, IRIS, and/or Master Index Card for full description of both the immunizations administered and the counseling provided. In client's chart, IRIS, and/or Master Index Card: Documentation must adhere to requirements in IAC 441-79.3(2). Note the review of record, need for immunization, anticipatory guidance provided, provision of VIS, date of VIS, follow-up plan, and any parent/guardian concerns or questions. Assure entry of immunizations in IRIS.	Typically VFC vaccine is used (at no cost to the agency or to the family). If there is a shortage of VFC vaccine, an IME Informational Letter will be provided with instructions. Due to NCCI edits, the following services will not pay when billed on the same date as 90460: • E & M • Well child exam codes (See IME Informational Letter #1219)	• Use 90460 for each vaccine administered. Submit your cost per your cost analysis. • For vaccines with multiple components (combination vaccines): Report 90461 for each additional component beyond the first component in the vaccine. Submit a nominal cost for accounting of the additional components. Examples: • HPV: 90460 • Influenza: 90460 • MMR: 90460, 90461 - 2 units • Tdap: 90460, 90461 - 2 units
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Immunization	Administration of immunizations These codes may be useful for children over the age of 18 years.	In CAReS: Under Health Screening Services category, mark "Immunization". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client's chart, IRIS, or Master Index Card for full description of services provided. In client's chart, IRIS, or Master Index Card: Documentation must adhere to requirements in IAC 441-79.3(2). Assure entry in IRIS.	Typically VFC vaccine is used (at no cost). If a child needs vaccine outside of the VFC cohort or if the child is age 18 to age 21, Medicaid can be billed for the vaccine. Do not bill 90471 with 90473. For subsequent immunization administration, use either 90472 or 90474 (as appropriate) with 90471 or 90473. Do not use these immunization administration codes if using 'immunization administration with counseling' (Code 90460/90461). If a child needs vaccine outside of the VFC cohort or if the child is age 18 to age 21, Medicaid can be billed for the vaccine. If there is a shortage of VFC vaccine, an IME Informational Letter will be provided with instructions. Due to NCCI edits, the following services will not pay when billed on the same date as these immunization administration codes: • E & M • Well child exam codes (See IME Informational Letter #1219)	Code 90471 for initial administration of vaccine (single or combination), subcutaneous or intramuscular Code 90472 for subsequent administrations of vaccine (single or combination) subcutaneous or intramuscular on same day as Code 90471 Code 90473 for administration of one vaccine (single or combination) by intranasal or oral means Code 90474 for subsequent administrations of vaccine (single or combination) by intranasal or oral means on the same day as Code 90473 Bill the appropriate administration code(s) and the code(s) for the VFC vaccine (at $0.00).
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Blood draw	Collection of venous blood by venipuncture Collection of capillary blood specimen Handling or conveyance of specimen for transfer to a laboratory	In CAReS: Under Health Screening Services category mark "Lab-Lead". Include in CAReS: 1. Specify if venipuncture, capillary draw, or handling/conveyance to lab. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2). If a CLPPP, assure entry in HLPPPS.	A blood lead draw and handling/conveyance cannot both be billed. Only one of the three codes can be billed. 15 µg/dL and above require venous draw confirmatory test. Venous blood lead levels of 20 µg/dL or higher result in automatic eligibility for Early ACCESS services for children ages 0-3. Referral to the Child Health agency for Early ACCESS service coordination will be made by the responsible CLPPP. Do not bill any of these codes if billing 'blood lead analysis' (Code 83655).	Code 36415 for venous draw. Code 36416 for capillary draw. Code 99000 for handling and conveyance to lab. Select only one of the above codes for billing. Note that these codes may deny as 'incidental services' if billed in conjunction with other direct care services.
Blood lead analysis	Collection of blood sample ***and*** lab analysis of blood lead level using the Lead Care II	In CAReS: Under Health Screening Services category mark "Lab-Lead". Include in CAReS: 1. Specify both the blood draw and the use of Lead Care II. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client's chart for full description of both the blood draw and the analysis using the Lead Care II. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2). If a CLPPP, assure entry in HLPPPS.	Do not bill codes 36415, 36416, or 99000 when using 'blood lead analysis' (Code 83655). The scope of Code 83655 includes the lead draw. The Lead Care II is the only CLIA waived testing device approved by IDPH. **Child Health agencies using the Lead Care II must report the results of all blood lead testing electronically to the Bureau of Lead Poisoning Prevention.** If a blood lead test result of 15 µg/dL or higher is obtained from a Lead Care II, a venous sample must be drawn and sent to a reference lab for a confirmatory test.	Code 83655 Venous blood lead levels of 20 µg/dL or higher result in automatic eligibility for Early ACCESS services for children ages 0-3. Referral to the Child Health agency for Early ACCESS service coordination will be made by the responsible CLPPP.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Other lab services	Hematocrit level Hemoglobin level Tuberculosis skin test	In CAReS: Under Health Screening Services category, mark the appropriate service. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2).	If hemoglobin testing is covered by the WIC program, it cannot be billed to Medicaid.	Code 85014: Hct Code 85018: Hgb Code 86580: TB
Vision Screening	Screening test of visual acuity, quantitative, bilateral. The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen Chart). (Code 99173) Instrument-based Ocular Screening (using approved instrument) (Code 99174)	In CAReS: Under Health Screening Services category, mark "Vision". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2). Include type of screening performed, tool used, results, referral/follow-up needed, and family questions/concerns.	Medicaid does not allow billing for an on-line vision screen.	Code 99173 (This code will not pay if provided with a well child exam.) Code 99174
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Speech audiometry	Speech Audiometry – threshold only This is a hearing screening.	In CAReS: Under Health Screening Services category, mark "Hearing". Include in CAReS: 1. Specify the speech audiometry service 2. First and last name of service provider & credentials if not entering own data. 3. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2). Include type of screening performed, tool used, results, referral/follow-up needed, and family questions/concerns.	There is no CPT code for the OAE hearing screen in Medicaid's Screening Center package.	Code 92555
Developmental test	Developmental test ***with interpretation and report***. This serves to identify children who may need more comprehensive evaluation. Use recognized instruments such as: ♦ Ages and Stages Questionnaire (ASQ) ♦ Parent's Evaluation of Developmental Status (PEDS) ♦ The Modified Checklist for Autism in Toddlers (M-CHAT)	In CAReS: Under Health Screening Services category, mark "Developmental Test". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2). Include: • Date of service • Name /copy of tool used (fully completed) w/service provider signature and date • Narrative report on the results and interpretation of results • Referrals /action taken/next steps • Family feedback /questions/ concerns • First name, last name, credentials, signature of service provider for notations	Do not use E & M for the following activities, as these are included in the scope of the developmental testing service: • Explaining the purpose of a developmental test • Scoring and interpretation of results of the test • Anticipatory guidance and • If indicated, referral to Level II testing. Adjusting age for prematurity is necessary if a child was born more than 3 weeks before his or her due date and is chronologically under 2 years of age. There is an online calculator at the following link. http://agesandstages.com/age-calculator/	Code G0451
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Emotional/ behavioral assessment with scoring and documentation	This is an emotional/behavioral assessment that includes the scoring and documentation (narrative description) of the service. The Ages & Stages Questionnaire: Social-Emotional (ASQ-SE) is approved for use	In CAReS: Under Health Screening Services category, mark "Emotional/behavioral assessment". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2). Include: • Date of service • Name /copy of tool used (fully completed) w/service provider signature and date • Narrative report on the scoring and summary documentation of results • Referrals /action taken/next steps • Family feedback /questions/ concerns • First name, last name, credentials, signature of service provider for notations	Do not use E & M for the following activities, as these are included in the scope of the emotional/behavioral assessment: • Explaining the purpose of an emotional/behavioral assessment • Scoring and reporting of results • Anticipatory guidance and • If indicated, referral for further evaluation.	Code 96127

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Nutrition counseling	Medical nutrition therapy - initial nutrition assessment and intervention, face-to-face with the individual Nutrition reassessment and intervention, face-to-face with individual Must be provided by a licensed dietitian.	In CAReS: Under Health Education Services category, mark "Nutrition Counseling". Select "clinic visit" as the interaction type. Include in CAReS: 1. Time in and time out including a.m. and p.m. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. Use for medically necessary therapeutic nutrition services beyond those provided through the WIC program. 2. Assure that criteria for providing therapeutic nutrition counseling services are met. 3. For Codes 97802 and 97803, a minimum of 8 minutes must be provided to bill the service.	Code 97802: Initial nutrition assessment & counseling (15 minute unit) Code 97803: Nutrition reassessment and counseling (15 minute unit) For determining 15 minute units: • 8-22 minutes = 1 unit • 23-37 minutes = 2 units • 38-52 minutes = 3 units • 53-67 minutes = 4 units
Counseling for obesity	This is face-to-face behavioral counseling for obesity. Must be provided by a licensed dietitian or an RN.	In CAReS: Under the Health Education Service category, mark "Counseling – Obesity". Select "clinic visit" as the interaction type. Include in CAReS: • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2).	Time in and time out are required.	Code G0447 (15 minutes)
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Nursing assessment/ evaluation	Nursing contact for the purpose of providing assessment and evaluation of a known medical condition such as: ♦ Failure to thrive ♦ Asthma ♦ Diabetes Must be provided by a registered nurse. Must include: ♦ Medical history including chief complaint ♦ Nursing assessment ♦ Evaluation ♦ Plan of care	In CAReS: Under Health Screening Services category, mark "Nursing Assessment". Select "clinic visit" as the interaction type. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2).	Intended for nursing assessment/evaluation outside of the home setting	Code T1001: Nursing assessment/evaluation This is an encounter code and is not based upon a timed unit.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Home visit for nursing services	Home visit made for the purpose of providing nursing services including: ♦ Medical history ♦ Nursing assessment ♦ Evaluation ♦ Nursing services ♦ Plan of care Must be provided by a registered nurse.	In CAReS: Under Health Screening Services category, mark "Nursing Assessment". Select "home visit" as the interaction type. Include in CAReS: 1. Time in and time out including a.m. and p.m. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. A home visit for care coordination service cannot also be billed for any portion of the home visit for nursing services. 2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the child health home visit for nursing services in addition. 3. This code is based upon an **hourly** unit of service. 4. A full 60 minutes of service must be spent on this home visit before oral health direct care can be separately billed.	Code S9123 (per hour) For time spent, include only face-to-face time. Do not include travel time (if applicable) or time documenting the service. A limit of ten units (hours) per client over a period of 200 days is placed on this code. Payment for services beyond this limit will require documentation to support the medical need for more visits.
Social work home visit	Home visit made for the purpose of providing social work services including: ♦ Social history ♦ Psychosocial assessment ♦ Counseling services ♦ Plan of care Must be provided by a BSW or licensed social worker.	In CAReS: Under Health Screening Services category, mark "Social Work Assessment". Select "home visit" as the interaction type. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client's chart for full description of services provided. In client's chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. A home visit for care coordination service cannot also be billed for any portion of the home visit for social work services. 2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the child health home visit for social work services in addition.	Code S9127 This is an encounter code and is not based upon a timed unit.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Evaluation and Management	Evaluation and management (E & M) for an office visit with an established client. Examples include but are not limited to E & M pertaining to: ♦ Follow-up visits subsequent to a full well child screen (on a date following the screen) ♦ Lead risk assessment (lead questionnaire), education about lead poisoning, and follow-up instructions when doing a blood lead draw. ♦ Service provided to an existing client at follow-up for an oral problem detected during previous screening service. Must be provided by an RN.	In CAReS: Under the Health Screening Service category, mark "Evaluation & Management". Select "clinic visit" as the interaction type. Include in CAReS: • Specify what the E & M is related to (e.g. well child screen, lead test, oral health screen, etc.) • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2).	E & M is a clinical encounter direct care service. This code ***cannot*** be used for: ♦ Providing care coordination services ♦ E & M on the same day as a full well child screen ♦ Explaining the purpose of a developmental test, interpretation of the test, anticipatory guidance, and needed referral to Level II testing when conducting a developmental test. (These activities are already included in the Code G0451.) Do not bill E & M related to immunization administrations. Instead use 'immunization administration with counseling' (Code 90460/90461).	Code 99211 This encounter code can only be used once per day per client.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Preventive medicine counseling	Use of this code is intended for: ♦ Counseling, risk factor reduction, and behavioral change intervention services related to testing for chlamydia and/or gonorrhea.	In CAReS: Under the Health Screening Service category, mark "Preventive medicine counseling". Select "clinic visit" as the interaction type. Include in CAReS: • Time in and time out including a.m. and p.m. • Specify what the preventive medicine counseling is related to (i.e. chlamydia and/or gonorrhea screening) • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2).	This service is provided at an encounter separate from a preventive exam by a practitioner. Codes 99401 and 99402 will not pay if another counseling-type code is billed for the client on the same day Code 99000 may be used for handling and conveyance of the chlamydia and/or gonorrhea specimens to a lab for analysis.	Code 99401 (15 minute unit) Code 99402 (30 minute unit) For determining a 15 minute unit: • 8-22 minutes = 1 unit For determining a 30 minute unit: • 16-45 minutes = 1 unit
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Depression Screening	This is depression screening using the PHQ-9*. • A caregiver of a child health client (99420) • An adolescent (G0444) (annual depression screen) Must be provided by an RN or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies. *Note: The Edinburgh Postnatal Depression Scale (EPDS) may be used as the tool for caregiver depression screening for up to one year following the birth of the child.	In CAReS: Under the Health Screening Service category, mark "Depression screen". Select "clinic visit" as the interaction type. Include in CAReS: • Specify who the depression screening is for – caregiver or adolescent • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2). Include name of tool, date/version of tool, results/scoring, interpretation of results, and referral/follow-up, and any other client questions/concerns.	Time in and time out are required for Code G0444. Documentation for a depression screening for a caregiver is located in the child's record (CAReS and chart). Assure that referral resources are available as needed. Assure that staff providing the service have been appropriately trained.	Code 99420 for caregiver of a child health client. Bill under the child's Medicaid number. Code 99420 is an encounter code and is not billed based upon time. Use Code G0444 for annual depression screening for adolescents (15 minute unit)
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Domestic Violence Screening	This is domestic violence screening using the Abuse Assessment Screen (AAS). • A caregiver of a child health client • An adolescent Must be provided by an RN or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.	In CAReS: Under the Health Screening Service category, mark "Domestic violence screen". Select "clinic visit" as the interaction type. Include in CAReS: • Specify who the domestic violence screen is for – caregiver or adolescent • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2). Include name of tool, date/version of tool, results/scoring, interpretation of results, and referral/follow-up, and any other client questions/concerns.	Documentation for a domestic violence screen for a caregiver is located in the child's record (CAReS and chart). Assure that referral resources are available as needed. Assure that staff providing the service have been appropriately trained.	Code 99420 for either caregiver of a child health client or an adolescent. If for the caregiver of a child health client, bill under the child's Medicaid number. Code 99420 is an encounter code and is not billed based upon time.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Mental health assessment	A mental health clinical assessment using a nationally recognized validated tool. This involves an integrated evaluation across a full range of life domains which leads to the development of an effective, comprehensive, and individualized plan of care. It is a thorough assessment of the individual's clinical and psychosocial needs and functional level. Must be administered by a licensed social worker (LISW, LMSW) or other licensed mental health professional.	In CAReS: Under the Health Screening Service category, mark "Mental health screen". Select "clinic visit" as the interaction type. Include in CAReS: • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2). Include name of the assessment tool, description of findings, plan of care, referrals, and client response/questions/concerns.	Assure that referral resources are available as needed.	Code H0031
Mental health services (e.g. psychosocial/ counseling)	This is a psychosocial/ counseling service that may be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family counseling, or a registered nurse.	In CAReS: Under the Health Screening Service category, mark "Counseling-Mental Health". Select "clinic visit" as the interaction type. Include in CAReS: • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2).	This psychosocial service shall include: • Demographic factors • Mental & physical health history and concerns • Family composition, patterns of functioning, and support systems • Identified needs • A plan of care based on the above • Counseling and anticipatory guidance as appropriate • Referral and follow-up services	Code H0046
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Alcohol and/or substance abuse screening w/ brief intervention	This is alcohol and substance abuse screening with brief intervention which includes administration of the following: • CRAFFT for adolescents under age 18 years • SBIRT for clients age 18 to 21 years • Brief intervention Must be provided by an RN or social worker (BSW or licensed).	In CAReS: Under the Health Screening Service category, mark "Substance abuse screen". Select "clinic visit" as the interaction type. Include in CAReS: • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2). Include name of tool(s), date/version of tool(s), results/scoring, interpretation of results, and referral/follow-up, and any other client questions/concerns. Documentation must also include the nature and outcome of the brief intervention.	Time in and time out are required. Brief intervention is a required component of the service. It incorporates principles of motivational interviewing. The CRAFFT includes • Administration of the tool • Brief intervention SBIRT = Screening, Brief Intervention, and Referral to Treatment The SBIRT includes: • Two question pre-screen • AUDIT - Alcohol Use Disorders Identification Test ***AND/OR*** DAST – Drug Abuse Screening Test • Brief intervention	Code 99408 for the child (15-30 minutes) Code 99409 for the child (over 30 minutes) For a billable service the following must be provided and documented: • The CRAFFT with brief intervention OR • The AUDIT and/or DAST with brief intervention If providing this service for a child's caregiver (over age 21, bill the service as a risk assessment – Code 99420 - under the child's Medicaid number.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Annual alcohol screening Alcohol and/or drug screening	Annual alcohol screening Alcohol or drug abuse screening These screening involve administration of the following tools: • CRAFFT for adolescents under age 18 years • AUDIT and/or DAST for clients age 18 to 21 years Must be provided by an RN or social worker (BSW or licensed).	In CAReS: Under the Health Screening Service category, mark "Substance abuse screen". Select "clinic visit" as the interaction type. Include in CAReS: • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2). Include name of tool(s), date/version of tool(s), results/scoring, interpretation of results, and referral/follow-up, and any other client questions/concerns.	For Code G0442, time in and time out are required for a minimum of 15 minutes of service. Use the following tools: • CRAFFT • AUDIT - Alcohol Use Disorders Identification Test ***AND/OR*** • DAST – Drug Abuse Screening Test These codes ***do not*** include the brief intervention component. Codes G0442 and H0049 cannot both be billed for the same day for the same client. Codes G0442 and H0049 cannot be billed in conjunction with Code 99408.	Code G0442 for annual alcohol screening (15 minutes) Code H0049 for alcohol and/or drug screening For a billable service, the following must be provided and documented: • The CRAFFT OR • The AUDIT and/or DAST If providing this service for a child's caregiver (over age 21), bill the service as a risk assessment – Code 99420 - under the child's Medicaid number.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Counseling for alcohol misuse	This is face-to-face behavioral counseling for alcohol misuse. Must be provided by a RN or social worker (BSW or licensed).	In CAReS: Under the Health Screening Service category, mark "Counseling – Alcohol misuse". Select "clinic visit" as the interaction type. Include in CAReS: • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client's chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2).	Time in and time out are required.	Code G0443 (15 minutes)
For more information on direct care services, refer to Medicaid's Screening Center Manual.				